ENVIRONMENT CANADA

ENVIRONMENTAL EMERGENCIES BRANCH

CRISIS MANAGEMENT

BIO-MEDICAL WASTES

FOLLOW-UP REVIEW

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Departmental Management Services Directorate

January 07, 1991

EXECUTIVE SUMMARY

The purpose of this follow-up review was to assess how well the April 1990 Bio-Medical Wastes incident was managed, and to apply lessons learned to the crisis management process within Conservation and Protection.

Information was gathered through research including interviews, written comments, review of available files, and a comparison of similar initiatives with like organizations. The results focus on a) factors which worked well, b) areas of concern, c) what was learned, and d) recommended areas for improvement.

The Bio-Medical Wastes issue, a media generated crisis, was handled proactively to eliminate the potential for embarrassment to the Department and, by implication, the government. The successful management of this crisis can be directly attributed to good preparation, strong leadership, organization, coordination, and a well-prepared communications strategy.

It was learned that four (4) key concerns dominated the review. The need for better interdepartmental co-operation, especially during a crisis, the development of logistics and support, the clarification of roles of crisis team members, and the addition of a post-crisis review process were mentioned most frequently.

The key recommendations to address these concerns are:

a) clarify the roles, responsibilities, and authorities exercised during a crisis by crisis team members, the Emergency Branch, internal department sections and involved sections of other departments,

b) complete bi-lateral agreements with other departments dealing with policy and procedure issues, and interdepartmental co-operation during a crisis,

c) prioritize the developing, strengthening, upgrading, and making available of effective logistics and support, and

d) establish a post-crisis review methodology.

Other recommended areas for improvement in this report address operational and crisis management planning concerns identified during this review.

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On April 19, 1990, a Montreal-based CBC reporter called the Waste Management Branch of Environment Canada and asked whether there had been any new developments on the Delson incident which involved the alleged illegal importation of U.S. wastes for disposal in Canada.

The reporter also disclosed that a joint CBC-Montreal and NBC-Nashville investigative story would be broadcast showing that Bio-Medical Wastes, concealed in other waste shipments, including waste paper destined for recycling, were being smuggled into Canada and parts of the United States.

As a consequence, management initiated a variety of actions to eliminate the potential for embarrassment of the department and, by implication, the government. A "Synthesis of Federal Response" summarizing the actions taken by Environment Canada are outlined in Appendix 8.6. The major actions to resolve this issue included:

a) the creation and coordination of a crisis team, and

b) the development and use of a communications strategy.

The crisis ended on Tuesday, April 24, 1990, after four (4) days of intense activity, when the CBC advised Environment Canada staff that the CBC "wants to work on the story longer", thereby deferring indefinitely the broadcast of the investigative story in Canada.

In an ongoing effort to maintain and enhance the efficiency and effectiveness of managing crises within Conservation and Protection, the Environmental Emergencies Branch requested a review of the Departmental response to assess how the bio-medical wastes issue was managed and what results can be applied to its evolving Crisis Management plan.

2.0 SCOPE

This report summarizes the results of a post-mortem analysis of the management of the Bio-Medical Wastes incident to assess how well the crisis was managed and to understand and apply what was learned to the crisis management plan.

Information was gathered through research including a follow-up questionnaire used during individual interviews with key participants in the crisis, written comments, review of available files, and comparisons of similar initiatives with like organizations such as Emergency Preparedness Canada and Canutec. Results focus on:

a) Factors which worked well,
b) Areas of concern,
c) Insights, and
d) Recommended areas for improvement

The review specifically excludes an analysis of how the incident happened.

The consensus of the crisis participants was that the response to the Bio-Medical Wastes issue was a success. Embarrassment of Departmental staff was avoided and the anticipated CBC broadcast of Bio-Medical Wastes smuggling did not take place. Also, the normal day-to-day operations of the Department were not disrupted by the crisis.

The combination of good planning and preparation, strong leadership, effective management, and thoughtful co-ordination significantly contributed to the success. A well thought out and broadly reviewed communications strategy must be highlighted here as the key success factor in the resolution of this crisis.

Logistics and Support

Operationally, the Department was ready. Work on the disposal of Bio-Medical Wastes had preceded the crisis, and the problem was already identified because of earlier investigations into Bio-Medical Wastes smuggling.

A recently installed but largely untried new computer system worked so well that no one remembered that, for most of the crisis, DOTS was not operational, due to a software upgrade.

Interdepartmental links were being fostered because Environment Canada and other Government department officials were negotiating bi-lateral agreements (Memoranda of Understanding) on crisis management co-operation.

Leadership

An effective combination of decision makers and leaders played a pivotal role in successfully managing this crisis.

a) A small group of seasoned, well trained and experienced crisis veterans was readily available. These staff members "carried the departmental memory" and understood how the organization functioned.

b) Early decisions, such as involving the ADM, Conservation and Protection and other Departments (Transport Canada, Customs, External Affairs, Privy Council Office, Health and Welfare) substantially eased the management of this crisis.

c) The decision to create a crisis team composed of operational, communications, and technical staff aided the management of this crisis.

d) The crisis was generally managed at the Director General (DG) level, with guidance and moral support provided by the ADM, Conservation and Protection.

Management

Members of the crisis group, who brought the right combination of skills and experience, were held together as a team by a strong crisis manager. Individuals were kept focused. The team was quickly organized through the identification of issues, tasks, roles, and action plans. Group members worked on the appropriate issue.

Staff involved in this crisis worked well together because they had experience and practice, had worked together before, and their behaviours under crisis conditions were well known to each other.

Group members were alert, focused, dedicated, self-disciplined, and brought to the crisis a versatility of management, operational, communications, technical, and interpersonal skills.

Staff co-operation, interaction, and the exchange of information was open and free of hesitation. The atmosphere of co-operation brought out the best in people.

The crisis manager took charge of specific situations so that potential problems were quickly eliminated. Examples are the identification of an action plan, assigning responsibilities, dealing with priorities, and ensuring the dissemination of information at appropriate times.

The crisis manager was successful because he had an effective combination of operational and conceptual skills. For example, while some of the conceptual questions were given a technical answer, he was able to translate this information into the overall needs of the organization.

Communications

Involvement of the Communications staff early in the process helped in the gathering of facts, identifying this incident as a communications issue, and later aided in the drafting of an effective communications strategy. The combination of these factors substantially contributed to solving the crisis.

a) Up to the time that Communications staff called the CBC to obtain detailed information - which was done very well - the direction on where this issue was going was mostly speculative.

b) The Bio-Medical Wastes issue was correctly identified as a media-generated crisis.

c) Questions and answers, press lines, and backgrounders supplied by other government departments were of good quality because of the lead taken by Communications staff.

d) Because Communications staff were fully informed, the development and successful implementation of an appropriate communications strategy was possible.

e) The quality of the briefing notes was high.

Overall, several areas of concern were identified by staff interviewed during this review. While all are identified below, the four(4) key concerns continue to be the:

a) Need for improved interdepartmental co-operation, especially during a crisis,

b) The availability of effective logistics and support,

c) The confusion over roles, responsibilities, and authorities exercised by crisis team members, and

d) The absence of a post-crisis review process.

Logistics and Support

Crisis team members consistently expressed their concern over the disarray of the crisis operations centre. Areas most mentioned were:

a) Layout and physical design, including poor air quality and inappropriate lighting,

b) Lack or inaccessibility of needed equipment and systems, such as regular and cellular telephones, pagers, fax machines, and recording equipment. For example, the crisis center was unable to access Montreal and U.S. television channels to determine if and what had been broadcast about the Bio-Medical Wastes issue (this information was discovered after the crisis),

c) Lack of security, such as the inability to isolate the crisis team, and outside interference, such as the demand for crisis information, or using crisis operations centre telephones,

d) Lack of human comforts such as the opportunity to prepare food, holding food and drink in inventory, and making available liquids other than coffee,

e) Staffing the centre for a crisis. The centre relies on outside personnel agencies for clerical and typist support, which in this case, took three (3) days to materialize. Contacting potentially available staff on a standby list had proven fruitless, in this case, and

f) Lack of immediately available information. Some of the team members expressed their concern over the time lapse between a decision made and the information received. Information had to be processed first, then copied and distributed for review.

Leadership

There was a concern that too small a group of knowledgeable managers handle the bulk of all crises. And it was a forgone conclusion that they should be called upon to handle the Bio-medical Wastes issue.

The majority of crisis members felt that the organization overreacted to the importance of the crisis.

There was a lack of consensus as to who the primary decision maker was. The Directors General of Environmental Protection, Emergencies Branch, and Waste Management Branch, and the Assistant Deputy Minister, Conservation and Protection were variously cited as the main decision maker.

Management

While the crisis had a very clear beginning with the early decisions made by Senior Management, it ended by simply "petering out". The predominant concensus was that a crisis ends when it is declared ended.

Occasional lapses in the decision making and the information dissemination processes occurred because of a lack of role definitions. This also led to a lack of clear understanding as to:

a) Who was in charge,

b) Who set goals,

c) Who made the decisions,

d) Who was responsible for what, and

e) Who shares information with whom, when, why, how and where.

Too many teams worked in isolation on various tasks (see Appendix 8.3).

There was a difference of opinion as to whether the Bio-Medical Wastes issue was a crisis.

There was a difference in perception as to what the prime issue was and therefore what goals had to be achieved (see Appendix 8.1 and 8.2).

Communications

Very few significant communications concerns were raised during the interviews.

Some departmental, as well as other Government departmental, staff were difficult to reach after business hours.

It was felt that an executive hotline should be available for direct communications with key executives.

Some surprising insights came to light as a result of this review. While most of these will be confirmations of information that is already known, a startling revelation is the way the organization systematically eliminated the negative factors as they appeared. For example, the Departmental Communications System (DOTS) was shut down during most of the crisis, but a user friendly backup system took over without flaw.

On Monday morning, just prior to a major conference call with other government departments, a "bomb threat" caused the evacuation of the building. The crisis operations centre manager had the presence of mind to hook into the cellular telephone system. It is to his credit that business was carried on from the parking lot across the street.

Some elements of luck were also present. For example, just as the "start-up team" was ready to proceeed at 5:30 P.M. Friday, the crisis operations centre officer walked into the centre on her way home, but was able to stay and provide crucial information to start up the crisis process. Precious time was saved, because the centre had not been physically manned all day. Staff was on call through the telephone system and beepers, which would have necessitated finding contact lists and making the necessary telephone calls. And even through some of the guidelines and procedures were in a state of flux (installation of new computer system; formation and evolution of the Emergency Branch), the staff assigned to the crisis possessed strong skills and crisis experience which, in their combination, helped to overcome all obstacles, and ultimately control the crisis.

The following insights deserve specific mention because of their importance to the evolution of effective crisis management.

Logistics and Support

Preparation, good logistics and support helped to make the management of this crisis a success. In addition, decisions were made on good information, and good information was available through well developed interpersonal relationships and the use of effective tools. In short, experience paid off.

The computer system, particularly, must be user friendly because occasional users, with minimal training, must be able to master its use under stressful conditions. The system must contain, or have access to, needed information such as contact and expert lists.

All staff working in the Emergency Branch should be prepared to work on, and be available for, crisis work.

Bi-lateral agreements with other departments cuts red tape and thereby speed responsiveness to a crisis.

Post-mortems are essential in getting the "wrinkles" out of the crisis planning process. The insights gained from this review confirm that the department would benefit from the implementation of a formal post crisis review methodology.

Leadership

During a crisis, the organization requires a good mix of strategic and operational thinkers and decision makers.

Early strategic decisions substantially eased the resolution of this crisis. The start-up team "prepared the way" for the crisis team.

By actively involving senior management before the crisis team was formed, the right perspective was quickly achieved. The issue was placed in its proper context.

The leader of the start-up team correctly chose to isolate a group of senior decision makers, which facilitated the discussion and the decision making process. The results of the crisis confirm that the right initial decisions were made before the crisis team got started.

Management

A crisis is a time for exceptional management, not panic or a suspension of good management practices. Managers trained in crisis management tend to behave very differently under crisis conditions, as was evidenced during the management of this incident. While crisis management must be seen as an autocratic process, the internal workings of the crisis team and those who are involved are best managed through consensus. If consensus cannot be reached, the crisis manager must have the power to make on-the-spot decisions.

The crisis manager must be the central clearing house for all information and decisions. If sub-groups of the crisis team or experts and advisors to the crisis team operate autonomously, all must report back to the crisis manager.

A balanced combination of management/operations, technical, and communications staff in the crisis team is more effective than other combinations in handling the crisis, because all three are needed to control a crisis.

There must be a common definition of a crisis.

The identification of the primary issue and goals is important to keeping the crisis team focused, and to achieve early crisis resolution.

The technical expert may not be the best crisis leader. The type of leadership required includes superior organizing skills, process skills, interpersonal skills, and a thorough knowledge of the organization.

The leader must have a balance of operational and conceptual skills. Staff reporting to the crisis manager must have team, interpersonal, and organizational skills, and be stress resistant.

A decision must be made on who decides what information leaves the crisis operations centre and the team.

Staff assigned to crises must be highly trained and must have credibility, and the confidence of management.

Communications

This crisis highlights the importance of using effective staff, systems, and processes within the department, interdepartmentally, and with the media. In addition, its successful conclusion rested on the inclusion of communications staff as full-fledged members of the crisis team. The need for the implementation of a well thought-out communications strategy based on agreed-upon goals was also important.

By implementing an effective communications strategy to control damage, crises can be reduced in intensity, be averted, or actually be eliminated.

Communications is important to the resolution of a crisis.

Answers to certain communications questions (what do you know?; when did you know it?; what actions were, or are being taken?) are important when responding to senior executive, media, and public inquiries.

In light of the positive aspects working for the resolution of this crisis, the areas of concern expressed by the post-review participants, and the insights gained as a result of this review, the following suggestions are made in order to facilitate the evolution of the crisis management planning process:

7.1 Clarify roles, responsibilities, and authorities exercised during a crisis, including:

a) Individual crisis team members,

b) Emergency Branch Operations,

c) Departmentally, and

d) Interdepartmentally

7.2 Complete bi-lateral agreements with other departments dealing with policy and procedure issues, and interdepartmental co-operation during a crisis.

7.3 Prioritize the developing, strengthening, upgrading and making available of effective logistics and support. This review identified three (3) areas: management of the crisis operations centre, staffing, and, procedures.

<u>Management of the Crisis Operations Centre</u>

a) Review the layout and physical design of the Crisis Operations Centre.

b) Make available dedicated equipment, such as back-up computer systems, regular and cellular telephones, high speed copiers, FAX machines, recording media, and pagers.

c) Develop the capability of isolating the crisis operations centre and the crisis team during a crisis from regular departmental operations.

d) Increase human comfort by providing such items as kitchen facilities, food inventory, air-conditioning, lighting.

e) Review security (facilities, equipment, information).

f) Develop and maintain crisis check lists to manage the process side, especially in the Crisis Operations Centre, by priority, seriousness, urgency.

g) Identify the prime issue and the goals to be achieved. Write these on the crisis operations centre board in plain view for all team members.

h) Provide a crisis budget and extend spending authority to the crisis operations centre manager.

Staffing

In conjunction with the Departmental Human Resources organization, identify internally available clerk/typist and administrative support which could be made available to the crisis operations centre.

a) identify needed skills,
b) compare skills against needs,
c) canvas staff interest,
d) obtain commitment/agreements from staff superiors, and
e) construct and maintain contact lists.

Procedures

As part of the crisis management plans and the operating process within the crisis operations centre, have in place a clear set of crisis management procedures and guidelines which start up the process when a crisis is identified, including:

a) Generic guidelines,

b) Computer start up,

c) Panic book,

d) Updated contact lists,

e) Decision process within crisis team, and

f) Crisis team procedures, such as:

.. issue and goals identification,
.. clarification of roles, and authorities,
.. how the team will manage itself,
.. Identification of spokesperson(s),
.. Systematic reviews,
.. Systematic way to develop briefing notes,
.. Conference call process,
.. Mechanisms to resolve conflict, and
.. How information is analyzed

7.4 Establish a post-crisis review methodology including:

a) A debriefing process for the crisis team shortly after the crisis is overcome,

b) A post-crisis contingency planning process so that decisions are ready if or when this or a similar crisis recurs,

c) A problem solving process which would address such areas as interdepartmental concerns, application of policies, regulations, and procedural problems, and the resolution of conflict,

d) An independent post crisis follow-up review process, to be activated one (1) to three (3) months after the conclusion of the crisis, and

e) the identification and rewarding of "crisis heroes".

7.5 Train more people to handle crises, to avoid a constant involvement of the best staff which at present consists of a small core of seasoned veterans.

7.6 Because speed is critical during a crisis, suspend having documents reviewed by the Briefing Unit. However, ensure that the Briefing Unit receives copies of all briefing notes.

7.7 After the crisis, visibly reintegrate the issue into the normal flow of business so that the responsible operation can deal with clean-up, compliance, and other ongoing matters.

7.0 CONCLUSION

This review summarizes the lessons learned as a result of the investigation of how well this crisis was managed.

It was learned that this incident was managed well because communications staff were included early in the process. Successful management of this crisis was also influenced by good preparation, strong leadership, organization, and co-ordination.

The clarification of roles, completion of bi-lateral agreements with other departments, strengthening logistics and support, and the development of a post-crisis review methodology dominated the concerns expressed during the interviews.

Finally, there was a strong sense among review participant that issues identified during this review should be addressed as soon as possible. The suggested areas for improvement reflect and address these concerns.

APPENDICES

THE PRIME ISSUE - A VARIETY OF VIEWS

---

1. Abating the potential for embarrassment.

2. Ensuring that the media had the right information, and that involved departments were co-ordinated, and making information available.

3. The possibility of a TV report saying illegal Bio-Medical Wastes were coming into Canada, and the government was doing nothing to prevent this.

4. Manage the response to the media effectively. Upon airing of the program, Environment Canada must be able to explain to Canadians the rationale of what the government is doing.

5. The importation of Bio-Medical Wastes and implementing some damage control.

6. Canada is becoming a dumping ground for Bio-Medical Wastes from the U.S. without having controls or regulations to prevent this.

APPENDIX 8.2

THE SECONDARY ISSUE - A VARIETY OF VIEWS

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1. Alleged illegal entry into Canada of Bio-Medical Wastes.*

2. Co-ordinating Federal Government Departments.

3. The general disposal of wastes.

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* This became the primary issue after the potential for embarrassment was eliminated. The process for both issues was virtually simultaneous.

BIO-MEDICAL WASTE TEAMS

START UP

L. Goulet
F. Guimont
J. Maxwell
P. Higgins
S. Hart
J. Myslicki
A. Bowcott

CRISIS TEAM

D. Kimmet	- Emergencies Branch
A. Bowcott/J. Maxwell	- Policy
E. Kulin/M. Colpitts	- Communications
S. Hart/S. Hunt	- Waste Management Branch
J. Myslicki/T. Dionne	- Waste Management Branch

POLICY

A. Bowcott
M. Ramsey

SUPPORT

P. Mazerolle
H. Crepeault
J. Menzies
G. Cloutier

Typist (Contract)

COMMUNICATIONS

M. Colpitts
E. Kulin
S. Hart (Spokesperson)

TECHNICAL

J. Myslicki
T. Dionne

APPENDIX 8.4

FOLLOW-UP REVIEW PARTICIPANTS

Special thanks are due to all participants in this review for their cooperation in providing their comments and ideas for improvements.

1. Sam Baird
2. Joe Slater
3. Mimi Ramsey
4. Heather Crepeault
5. Peter Mazerolle
6. Dale Kimmett
7. Andy Bowcott
8. Lynne Provost
9. Mark Colpitts
10. Jim Maxwell
11. Gerald Aubry
12. Alain Jolicoeur
13. Ann Wardrop
14. Michel Cloutier
15. Francois Guimont
16. Peter Higgins
17. John Myslicki
18. Don Campbell
19. Tricia Davis
20. Steve Hart
21. Eleanor Kulin
22. Lorette Goulet
23. Judy Ferguson (PCO)
24. K. Rozee (HW)
25. John Reid (DOT)
26. Jim MacKenzie (Customs)
27. Margo Schwartz (External Affairs)

APPENDIX 8.5

FOLLOW-UP QUESTIONNAIRE

BIO-MEDICAL WASTES

FOLLOW-UP QUESTIONNAIRE

1. How was the crisis identified? When did it start?

2. How and when did this crisis come to your attention? Before or after the crisis team was formed?

3. What was the prime issue in this crisis?

4. Did the prime issue change during the crisis?

5. Were there secondary issues?

6. Who was involved in the crisis?

7. Who were the members managing the crisis?

8. Who should have been involved?

9. Who should not have been involved?

10. What was your level of participation?

11. Were any of your staff involved?

12. How was the crisis managed? Why?

13. How was the crisis coordinated? Why?

14. Assess the communication process.
    Internal lines of communication
    External lines of communication
    Availability of information on the crisis:
    Timeliness of information
    Availability of current and correct contact lists.

15. Describe the degree of ease with which people could be reached

    Internally: During business hours
    : Outside business hours
    Externally: During business hours
    : Outside business hours

16. Describe the degree of ease with which decisions could be obtained

    Internally: During business hours
    : Outside business hours
    Externally: During business hours
    : Outside business hours

17. Was it clear who had decision making authority? Who had it? Why?

18. Were all people involved connected to DOTS?

19. Assess the technical and administrative support provided during the crisis?

20. Assess how people responded.

21. If this crisis happened again, would we

    a) declare this a crisis? Why?
    b) handle it differently? Why?

22. When does a crisis end?

23. What worked well? Why?

24. What did not work well? Why?

25. What should be improved?

26. What did we learn from this?

APPENDIX 8.6

SYNTHESIS OF FEDERAL RESPONSE

ALLEGED ILLEGAL IMPORTATION OF U.S. BIO-MEDICAL WASTES

SYNTHESIS OF FEDERAL RESPONSE

Facts/Background

On April 19, 1990, a Montreal-based CBC reporter called Environment Canada's Waste Management Branch asking whether there had been any new development on the Delson incident which involved the alleged illegal importation of U.S. wastes for disposal in Canada.

The reporter also disclosed that a joint CBC-Montreal and NBC-Nashville investigative story would be broadcasted showing that bio-medical wastes, concealed in other waste shipments including waste paper destined for recycling, were being smuggled into Canada and parts of the United States.

Date	Event	Federal Response	Rationale
April 19	Reporter calls EC operational unit to ask about Delson follow-up, implying knowledge of additional similar occurrences	Reporter is given information & also referred to Customs.	
April 20	Operational Unit brings matter to Communication Unit's attention	Communication Unit contacts reporter & offers return call by senior official to provide information on bio-medical waste management (Offer is declined) EC operational unit contacts TC, EA & Customs to establish basis for story & confirm respective jurisdictional responsibilities in the situation EC formally initiates contact with Customs, TC, H&WC, PCO and EA in order to coordinate federal activities as a result of allegations	Alleged illegal entry of bio-medical wastes needs to be pursued

Date	Event	Federal Response	Rationale
April 20		EC alerts regional offices of alleged infractions	
April 23	CBC researcher calls EC to obtain comments on certain segments of the story	EC senior official explains his concern about distortion of story's focus & suggests EC official be given live interview at end of story to provide correct perspective	CBC's mistaken perception of problem due to lack of general knowledge & comprehension of issue
		EC advises all Canadian Council of Ministers of the Environment Waste Management Committee members of alleged illegal entry of bio-medical wastes	
		EC leads discussion with relevant federal departments on respective involvement in alleged violation cases, including restrictions on policing ability. Departments agree to investigate allegations	Inability to do a thorough inspection of all import shipments in order to prevent, detect and prosecute violations.

(Based on the premise that most importers make true declarations at border points, control is exercised through regular monitoring activities that include identifying regular importers and visual checks. More intensive inspection blitzes are carried out when illegal entries are suspected, concentrating especially on highly used border crossings.)

	CBC indicates postponement of broadcast		
April 24	CBC provides EC with proposed interview questions	Senior official explains in detail the rationale for federal government's responses to alleged illegal acts	

Date	Event	Federal Response	Rationale
April 24	CBC decides to further delay broadcast to allow review of story	Relevant government departments keeping alert and ready to react to revised story	In order to provide guidance & advice if required

APPENDIX 8.7

TERMS OF REFERENCE

ENVIRONMENT CANADA

ENVIRONMENTAL EMERGENCIES BRANCH

CRISIS MANAGEMENT

BIO-MEDICAL WASTES

FOLLOW-UP REVIEW

TERMS OF REFERENCE

Prepared by

A.K. Stockmann
Consulting and Administrative Practices
Departmental Management Services
Directorate

September 19, 1990

BACKGROUND

In an ongoing effort to maintain and enhance the efficiency and effectiveness of managing crises within Conservation and Protection, the Chief of the Crisis Management Division requested a review of the response to the bio-medical waste issue in Spring 1990.

On April 19, 1990, a Montreal-based CBC reporter called Environment Canada's Waste Management Branch asking whether there had been any new development on the Delson incident which involved the alleged illegal importation of U.S. wastes for disposal in Canada.

The reporter also disclosed that a joint CBC-Montreal and NBC-Nashville investigative story would be broadcasted showing that bio-medical wastes, concealed in other waste shipments including waste paper destined for recycling, were being smuggled into Canada and parts of the United States.

A summary of the actions taken by the Department are listed in Appendix "C".

From the results of this review, Management and staff of the Environmental Emergencies Branch expect to be able to improve on existing procedures.

OBJECTIVES

The purpose of this review will be to perform a post-mortem analysis of the management of the bio-medical waste issue, to

a) assess how well the crisis was managed

b) understand and apply learnings from the handling of this issue.

The review specifically excludes an analysis on how the issue happened.

DELIVERABLES

At the conclusion of this project, the analysis will have delivered:

1. factors which worked well

2. areas of concern

3. areas of improvement

METHODOLOGY

The project, to be conducted according to the five (5) project phases outlined in Appendix "A" and "B", will include:

1. The development, completion, and analysis of a short questionnaire.

2. Interviews with selected key members involved in this issue.

3. Data gathering and analysis on

   a) what worked well
   b) what did not work well
   c) what could be improved

4. Preparation and submission of report.

5. Feedback to the client.

6. Decision with the client on further action.

It must be emphasized that this review is conducted as a learning experience.

ORGANIZATION AND DIRECTION

The Director, Environmental Emergencies Branch and the Chief, Crisis Management will be the client.

André K. Stockmann (CAP/DMSD) will conduct the review, act as facilitator and analyst, and report to the client.

COST

Any transportation and related travel costs will be paid by the client.

The cost of the consultant and the report production costs will be carried by CAP.

APPROVAL OF TERMS OF REFERENCE

The following persons, by their signatures, approve these terms of reference.

SEP 20 1990

Director, Environmental Emergencies Branch

20.09.90

Director, Consulting and Administrative Practices

SEP 20 1990

Chief, Crisis Management

BIO-MEDICAL WASTES FOLLOW-UP REVIEW
PROJECT SCHEDULE

APPENDIX "A"

PROJECT PHASE	A 6 13 20 27	S 3 10 17 24	O 1 8 15 22 29	N 5 12 19 26	D 3 10 17 24 31	J 7 14 21 28	ESTIMATED HOURS	ACTUAL HOURS
PLANNING & REVIEW		———					20	28
DATA GATHERING			———————	———			40	58
INTERVIEWS			———————	———			60	43
ANALYSIS				———————	———		60	62
STATUS REPORTS			– –	– –	–		-	6
DRAFT REPORT				———			-	54
FINAL REPORT					———		40	9
							220	259

20.09.90
UPDATED 12.12.90

APPENDIX "B"

Planning and review	:	Issue identification	
	:	Planning/Preparation	
	:	Background Data	
	:	Related Data	
	:	Terms	
	:	Approval to proceed	
Data Gathering	:	Existing information	
		Manuals	Files
		Forms	Lists
		Charts	
		Procedures	
		Policies	
	:	Training Information	
	:	Procecures Information	
Interviews	:	2 hours x 13* = 26	
		2 hours x 7 = 14	
		Planning for interviews = 20	
		at 50% of i/view time	
		TOTAL 60	
Analysis	:	Identifying all steps	
	:	Verification	
	:	Identifying needed steps	
	:	Identifying redundant steps	
	:	Observations	
	:	Recommendations	
Reports	:	Verbal Status	
	:	Final Report	
	:	Feedback Meetings	

* Based on the Bio-Med Distribution List

APPENDIX 8.8

CORRESPONDENCE

MEMORANDUM NOTE DE SERVICE

Stockmann/997-1469/lm

To/À

DISTRIBUTION

From/De

A.K. Stockmann
Consulting and Administrative Practices
Finance and Administration

Security-Class.-Sécurité
Our file -N /Référence
Your file -V /Référence
Date October 2, 1990

OBJET
SUBJECT: BIO-MEDICAL WASTES - FOLLOW-UP REVIEW

In an ongoing effort to maintain and enhance the efficiency and effectiveness of managing crises within Conservation and Protection, Sam Baird, Chief, Crisis Management requested that we assist in a review of the response to the bio-medical waste issue in Spring 1990.

The purpose of this review will be to:

a) assess how well the crisis was managed
b) understand and apply what we have learned

From the results of this review, Management and staff of the Environmental Emergencies Branch expect to be able to improve on existing procedures.

In order to expedite this exercise, a set of questions (attached) was prepared which we wish to review with you. We feel that your input will be invaluable to this process.

In addition, because some time has passed since this incident occurred, we thought it helpful to enclose the "synthesis of federal response" summarizing the actions taken by the Department to resolve this issue.

We will contact you shortly to arrange for a brief interview.

A.K. Stockmann

Attach.

9.0 PRESENTATION

BIO-MEDICAL WASTES

FOLLOW-UP REVIEW

January 1991

THE BEST QUOTE

CRISIS MANAGEMENT
IS NOT A DEMOCRATIC
PROCESS

OBJECTIVE

- CONDUCT REVIEW TO ASSESS HOW WELL CRISIS WAS MANAGED
- UNDERSTAND AND APPLY INSIGHTS

BENEFITS

- GAIN USEFUL INSIGHTS
- POSITIVELY AFFECT CRISIS PLAN
- MAKE IMPROVEMENTS ON PROCEDURES
- MAKE IT EASIER TO MANAGE A CRISIS

DELIVERABLES

- WHAT WORKED WELL
- AREAS OF CONCERN
- INSIGHTS
- AREAS OF IMPROVEMENT

FOCUS

- LOGISTICS AND SUPPORT
- LEADERSHIP
- MANAGEMENT
- COMMUNICATIONS

METHODOLOGY

- REVIEW EXISTING DOCUMENTATION
- GATHER INFORMATION
- REVIEW RELATED INFORMATION
- ANALYZE DATA
- DESCRIBE WHAT WORKED WELL
- IDENTIFY AREAS OF CONCERN
- DESCRIBE INSIGHTS
- MAKE RECOMMENDATIONS
- DECIDE ON NEXT STEPS

ISSUES AND OBSERVATIONS

WHAT WORKED WELL?

- STAFF EXPERIENCED AND READY
- GOOD DECISIONS, GOOD CO-ORDINATION
- GOOD COMMUNICATIONS STRATEGY
- CRISIS TEAM COMPOSITION
- COMPUTER SYSTEM BACKUP

AREAS OF CONCERN

- ROLES, RESPONSIBILITIES
- INTERDEPARTMENTAL CO-OPERATION
- LOGISTICS AND SUPPORT
- POST-CRISIS REVIEW METHODOLOGY

INSIGHTS

- EXPERIENCE PAYS OFF
- PREPAREDNESS IS CRITICAL
- BI-LATERAL AGREEMENTS CUT RED TAPE
- CRISIS TEAM COMPOSITION IMPORTANT
  MANAGEMENT, COMMUNICATIONS, TECHNICAL
- CRISIS MANAGEMENT IS DIFFERENT FROM
  NORMAL MANAGEMENT

WHAT COULD BE IMPROVED?

- ROLES CLARIFICATION
- BI-LATERAL AGREEMENTS
- LOGISTICS AND SUPPORT
- POST-CRISIS REVIEW METHODOLOGY
- TRAINING
- MANAGEMENT PRACTICES
- POST-CRISIS REINTEGRATION

BIO-MEDICAL WASTES

THE HOT SPOTS

ROLES CLARIFICATION

LOGISTICS AND SUPPORT

TRAINING

UNANSWERED ISSUES AND QUESTIONS

- WHAT WOULD HAVE HAPPENED IF A LOWER LEVEL MANAGEMENT CRISIS TEAMS HAD WORKED ON THIS ISSUE?
- DOES THE CRISIS PLAN CONTAIN AN INTERDEPARTMENTAL CRISIS TEAM MECHANISM?
- WHAT HAPPENS WHEN 2 OR 3 CRISIS OCCUR AT THE SAME TIME?
- HOW EFFECTIVE IS THE CRISIS MANAGEMENT PROCESS IN THE FIELD, AWAY FROM HEADQUARTERS?

RECOMMENDATIONS

- CLARIFY ROLES
- COMPLETE BI-LATERAL AGREEMENTS
- IMPROVE LOGISTICS AND SUPPORT
- INSTALL POST-CRISIS REVIEW PROCESS
- TRAIN MORE STAFF

COST ESTIMATE

STAFF	$ 25K
EQUIPMENT	10K
FACILITIES	10K
OTHER	10K
	$ 55K

THE NEXT QUESTION

WHAT NEXT